

Child Victim: Jenica Randazzo, Age 9

Date of Death: February 6, 2015

County: Pasco

FSFN Report: 2015-034317

DCF Region: SunCoast

Judicial Circuit: Circuit 6

Date QA Review Completed: April 17, 2015



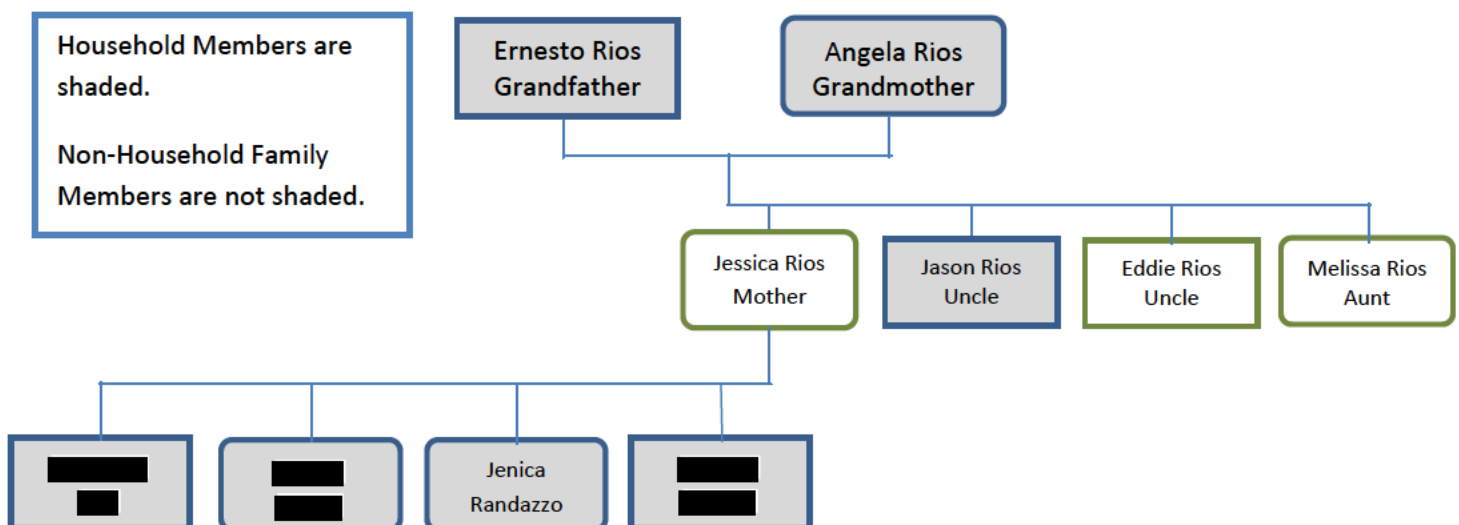
I. Introduction

On February 5, 2015, Jenica Randazzo [REDACTED] attacked by [REDACTED] maternal uncle, Jason Rios. [REDACTED] rushed to the hospital, and Jenica later died from her injuries. During the attack, Jason also killed his mother. At the time of the attack, Jenica [REDACTED] living with [REDACTED] maternal grandparents, Ernesto and Angela Rios, who were in the process of adopting [REDACTED]. The uncle was a household member and was a caregiver [REDACTED]. Despite the challenges posed with placement [REDACTED] with [REDACTED] grandparents, the case management organization was thoughtful in creating a comprehensive plan to address the needs of [REDACTED] and place [REDACTED] in a stable home environment. This placement decision was further supported through the provision of an array of services designed to meet the behavioral health needs [REDACTED] and sustain [REDACTED] in this placement long-term.

II. Case Participants

Participant Name	Age	Relationship/Role
Jenica Randazzo	9 years	Decedent, homicide victim
[REDACTED]	4 years	Half-Sibling
[REDACTED]	7 years	Half-Sibling
[REDACTED]	13 years	Half-Sibling
Jason Rios	24 years	Maternal Uncle, perpetrator, currently incarcerated
Angela Rios	55 years	Maternal Grandmother, homicide victim
Ernesto Rios	55 years	Maternal Grandfather

III. Family System Analysis



IV. Child Welfare Summary

The Department received the first report involving [REDACTED] Jenica in October 2005, and over the next six years, five more reports were received. [REDACTED]

Jenica was placed with the paternal grandmother. The case was transferred to the Community Based Care Lead Agency, Eckerd Community Alternatives, for ongoing case management. In April 2012, Jenica was moved to the maternal grandparents [REDACTED] after an incident of abuse at the paternal grandmother's home. [REDACTED]

[REDACTED] Jenica, [REDACTED] was in seven foster homes. Jenica's longest foster placement was [REDACTED] from October 2013 to June 2014, with the rest being only weeks at most.

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

The following specific recommendations were provided regarding steps to take prior to placement with the grandparents and were completed as advised:

- Alarms, locks and mirrors should be provided for the home so that the grandparents can supervise [REDACTED] adequately.
- [REDACTED]
[REDACTED]
[REDACTED] Jenica should be moved [REDACTED]
- Services must be in place prior to any move. The clinician should assist the grandparents in working with their support system to ensure that their natural supports are participating in activities that will be helpful in ensuring the safety [REDACTED].
- [REDACTED]
[REDACTED]

The following were additional recommendations that were made:

- Full exploration of which members of the extended family might be able to care [REDACTED]
[REDACTED]
[REDACTED]
- If the grandparents are not able to care [REDACTED], then all extended family should be ruled out before considering adoption outside of the family.

In June 2014, two relatives and a neighbor did undergo background screening to ensure that they were able to provide support to the grandparents. Additionally, the grandparents did advise in their Adoption Home Study that the maternal aunt was their long term "back-up" [REDACTED]
[REDACTED]
[REDACTED]

[REDACTED] The recommendations made through the Comprehensive Behavioral Health Assessment were followed, including a slow transition into the home and the implementation of an extensive safety plan.

V. System of Care Review

a) Practice Assessment

Finding: During the course of this case, case management staff demonstrated sufficient information collection and a "big-picture" view of the family. However, the grandparents regularly minimized the danger the mother was placing [REDACTED]

Information collection and assessment were demonstrated through the request of the Comprehensive Behavioral Health Assessment in order to help in the assessment of the grandparents, the reunification [REDACTED]
[REDACTED], the quality and level of intensive services that were implemented prior to [REDACTED]

investigation was closed with Not Substantiated findings. There was a chronological entry that the investigator had informed the adoption case worker of the overall investigative findings.

b) Organizational Overview

Finding: At the time of the incident, the protocol in place between investigations and case management in Pasco County that provided guidance regarding communication and sharing of information between agencies when a new investigation was received on an open case management case consisted of a telephone call from the investigator to the case manager.

The Department of Children and Families in the SunCoast Region covers four judicial circuits and 11 counties. One of those circuits, Circuit 6, consists of Pasco and Pinellas Counties. Child Protective Investigations in Pasco County are performed by the Pasco County Sheriff's Office Child Protective Investigations Division (CPID) through a grant agreement with the Department. Ongoing case management services are provided under the direction and supervision of Eckerd Community Alternatives (ECA), the community based care lead agency. The lead agency subcontracts with multiple providers to offer an array of services to families in Pasco County, to include: diversion services, foster care licensing and placement, case management services, adoption assistance, etc. In this case, Youth and Family Alternatives was the designated case management organization in Pasco County responsible for ongoing case management services.

During the June 2014 child abuse investigation conducted by the Pasco Sheriff CPID, the uncle informed the investigator that he had been Baker Acted two times, most recently a year ago. However, the uncle denied any mental health issues or being on any medication. He reported that his parents called law enforcement after he refused to go voluntarily, and he was then Baker Acted. Further exploration into this incident revealed there were no law enforcement call outs to this family's home in reference to mental health issues or Baker Acts regarding any of the family members. It was not discussed with the Adoption Case Manager; however, it was entered into the notes of the investigation.

ECA has taken action to improve communication through a local requirement to staff new abuse reports and ensure communication between the case management organizations and the child protective investigators throughout the life of the investigation. Additionally, ECA has built an alert into its Mindshare reporting software that supplements FSFN alerts, so that Eckerd leadership is aware of and reviews all abuse reports with ongoing case management services upon receipt.

c) Service Array

Finding: The service array for the grandparents and [REDACTED] was sufficient and accessible to provide the necessary supports and meet the needs of [REDACTED].

At the time of Jenica's death, the family was actively engaged with multiple child welfare and behavioral health providers – working with the family both within and outside of the home. None of the providers had expressed concern regarding the safety of [REDACTED] the grandparents' home.

[REDACTED]
[REDACTED]. Ernesto and Angela Rios began working with Baycare's Urgent Family Care (UFC) program in September 2013. The UFC counselor worked with the family on Intensive Parenting and family counseling twice per week. [REDACTED]

[REDACTED] This program played a key role in assessing the grandparents' readiness [REDACTED], making recommendations to the team, and supporting the family through the transition [REDACTED] back into the Rios' home. UFC continued to provide these in-home services to the family [REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
Angela and Ernesto Rios signed up for support services through Kinship Care on 5/28/14 and began receiving financial and emotional support from them in June 2014.

[REDACTED]
[REDACTED]
[REDACTED]
Jenica returned to the Rios' home 6/19/14 and was linked with Healing and Educational Alternatives for Deserving Students (HEADS) for weekly counseling. She also received medication management through Sequel Care for psychotropic medications for ADHD.

[REDACTED]
[REDACTED]
Youth and Family Alternatives also paid for environmental changes to the home to enhance safety measures, including door alarms and sight/sound monitors, the last of which was provided on 7/3/14.

VI. Summary

As with many families known to the child welfare system, this family had a long history of involvement that included the mother's struggle with substance misuse, incidents of domestic violence, and mental health issues.

[REDACTED]
[REDACTED] Due to continued placement moves, [REDACTED]
[REDACTED] an adoptive placement with the grandparents was explored. Using information from the Adoption Home study, the Comprehensive Behavioral Health Assessment and information provided from case managers involved in the case, the Adoption Review Committee

ultimately recommended placement [REDACTED] with the maternal grandparents. The decision was not arbitrary and was made with recognition of the difficulties inherent with this placement. The provider understood that the grandparents would be faced with many challenges [REDACTED]

[REDACTED] In an effort to make the most appropriate placement decision and support the placement, the provider:

- Brought the case to the Adoption Review Committee for review,
- Slowly transitioned [REDACTED] through overnight visits,
- [REDACTED] final placement [REDACTED] so that the grandparents [REDACTED] could get adjusted,
- Ensured [REDACTED] enrolled in counseling,
- Designated the case "high risk" requiring weekly case worker visits and
- Provided Intensive Services.

When tragic incidents such as this occur, it has a devastating impact - not only on the family, but also on those involved in the child welfare system of care. The Department of Children and Families and our partners at Pasco County Sheriff's Office CPID, Eckerd Community Alternatives, and Youth and Family Alternatives are all committed to continuing to review and improve our system of care. This review did immediately identify opportunities for improvement. Eckerd has taken actions to strengthen the communication between Child Protective Investigators and case/adoption managers, and the Department has already begun to determine whether changes are needed regarding the Adoption Home Study process. The Department also has initiated a review of Florida Administrative Code 65C-16 (Adoptions). This report, along with other reports regarding child fatalities, will be used by the Department and our partners to determine if other systemic improvements are needed.